5 Structural and Functional Change in Medicine

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> Being a doctor was once a beautiful profession. Satisfied doctors still exist today, but they have become rare. Their medical competence is greater than ever, and yet they increasingly have to put up with criticism. This relates both to the rising costs of medical action and to a growing discrepancy between the expectations that medicine fulfils and those that it disappoints.
>
> Meyer-Abich 2010: 13

Abstract: The health care system is in a crisis that can no longer be mastered by the increased use of technical and scientific progress in the

reductionist sense of biomedicine (§ 4) alone, but rather requires a fundamental *change in the relationship* between doctor and patient. As will be further explained in the following, the development trend from the care of *acute* diseases to *chronic* diseases requires a stronger participation and cooperation of patients in decision-making and therapy (§ 10, 22, 26, 29). This therapy can no longer simply be "ordered" or "prescribed" by the doctor according to the traditional, paternalistic model, but is to be negotiated and answered for jointly by both partners in a trusting relationship. Overall, the structural and functional change in the health care system has led to a communicative turn in medicine, which in the FRG was already put in a nutshell early on by Paul Lüth (1986) by programmatically calling for a development "from silent to speaking medicine".

These two development trends, both the changed spectrum of illnesses and the communicative reorganisation of the doctor-patient relationship that has become necessary as a result, must be taken into account in a reform of medical education and training, which must already be oriented towards a "doctor's image of the future". The discrepancies between the traditional and a future image of the doctor have been worked out in a variety of research and expert reports (e.g. Wissenschaftsrat 1992, Murrhardter Kreis 1995, Dörner 2001, Troschke 2004, Sachverständigenrat 2009, Meyer-Abich 2010, BMBF 2017, NKLM 2021, Robra 2023). Despite all differences in detail, there is a broad consensus that the future doctor must above all acquire certain key competences that allow flexible adaptation to changing requirement profiles of the medical profession (§ 6). These include above all communication, cooperation and team skills, but also skills of learning itself ("lifelong learning"), which are to be demonstrated both in collegial exchange and in the everyday practice of patient care.

These key competences of the doctor are subject to diverse developmental conditions in medical research and practice as well as in study reform and continuing education, which in turn are subject to social, demographic, economic, institutional, etc. conditions. We begin (§ 5.1) with a brief description of the socio-economic structural and functional change of medicine in the health care system and then describe (§ 5.2) the change in the mortality spectrum and the correspondingly changed competence profile of the doctor, who must take into account different concepts of health and disease (§ 5.3). Finally, we address the necessities, possibilities and problems of evidence-based guidelines in medicine (§ 5.4), which will concern us again in medical decision-making (§ 10).

This excursus on the guideline discussion seems necessary to us, because in perspective it is about the development of evidence-based guidelines for doctor-patient communication. Our handbook should also make a possible theoretical, didactic and empirical contribution to this in terms of its structure and function, as is also explicitly claimed by textbooks in the English-speaking world (e.g. Fortin et al. 2012).

5.1 Socio-economic change

Despite improved education and training, doctors continue to be criticised and disappoint a portion of their patients, as was prefaced by quoting the motto from Meyer-Abich's book on the "Philosophy of Medicine" (2010) (subtitle). This criticism is less due to personal failure than to structural conditions, the disregarding or changing of which often exceeds the possibilities of individual doctors. In the following, we will describe the medical competence profile, which was also foresightedly drafted by the Murrhardter Kreis (1995) for the "doctor's image of the future", under the current social and institutional development trends (§ 5.1), before we then (§ 5.2) go into detail about the necessary adaptation of the doctor-patient relationship and communication to the changed spectrum of illnesses.

5.1.1 Development trends

The *structural and functional change* in medicine is a complex development process that can hardly be reduced to a few parameters. The fact that the traditionally trained doctor is no longer up to the present and future requirements of medical care has been elaborated in many ways (e.g. Wissenschaftsrat 1992, Murrhardter Kreis 1995, Dörner 2001, Troschke 2004, Sachverständigenrat 2009, Meyer-Abich 2010, Herzog et al. 2013). Without fundamentally casting doubt on the Hippocratic tradition, medical practice can no longer be measured solely by virtue *ethics,* according to which the doctor is characterised above all by personal qualities such as *helpfulness*, *unselfishness*, *truthfulness*, *discretion*, *prudence*, etc. Despite the necessity of a multifactorial explanation, the following, partly contradictory development trends in medicine can be distinguished, which have largely contributed to a change in the traditional doctor-ideal as well as the doctor-patient relationship. [1]

1. **Technisation**
   The danger of an independent momentum of bio- and medical-technical developments, which Karl Jaspers (1958/86) already critically reflected on, raises not only the question of constantly changing, novel treatment goals and methods, but also the question of the medical-ethical permissibility of what is feasible and desirable, which often exceeds the competences of both the individual doctors and their patients. For this reason, "third parties" (e.g. health authorities, associations, insurance companies, ethics committees, etc.) become invisible but influential "players" in the dyadic relationship between doctor and patient, "talking into" the "dialogue" between doctor and patient.

2. **Specialisation**
   In addition to technisation, increasing professional specialisation can lead to a loss of general medical as well as psychosocial competences, which are indispensable for the holistic treatment of patients. The *dualism* between a *medicine without souls* and a *psychology without bodies* (§ 4), which was not only lamented by von Uexküll, is not only perpetuated, but also experiences further specialisation in both areas, which imposes narrow professional limits on the actors thus trained (entirely in the sense of Parsons 1951/70).

3. **Standardisation**
   In view of these technical-scientific developments, the individual decision-making competences of the doctor and the patient are increasingly limited. Their decisions must meet standards such as those formulated by medical ethics committees or, in the sense of *evidence-based* medicine (EBM), by general and specialist *guidelines* for care (§ 5.4, 10.3, 29). In individual cases, this may be seen as a simplification, relief and security, or as a restriction and paternalism of

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[1] For general overviews, each with a specific focus, reference is made to Anschütz 1988, Pellegrino 1989, Pellegrino, Thomasma 1981 and 1988, Viefhues 1989, Wieland 1986, Wolff 1989, Veatch 1989, Koerfer et al. 1996, Woopen 2001, Schmacke 2006, Noelle et al. 2006, Sachverständigenrat 2009, Meyer-Abich 2010, Pilnick, Dingwall 2011, Gigerenzer, Gray 2013, NKLM 2021, Ehlich 2020 and 2022, Robra 2023.

medical action ("cookbook medicine", "prescriptive" medicine), for example when evidence-based medicine seems to conflict with *shared decision making,* which we will come back to separately (§ 10, 22).

4. **Economisation**
   Medical practices and clinics are increasingly challenged as companies that are forced to balance medical activities under the dictates of *economic efficiency.* From this perspective, time-consuming consultations, for example, must be considered unattractive in the current billing system, so that they are pushed back as a central instrument of anamnesis, diagnosis and therapy, despite their proven *effectiveness* or *efficiency* (§ 1.1). At the same time, the doctor is functionalised as a *gate keeper* (e.g. already Pellegrino, Thomasma 1988), who, in view of scarce social resources, sees him or herself exposed to problems of *distributive justice* and *social compatibility,* for example, and can thus by no means always act in the best interests of "his" or “her” individual patient. Not least under the economic aspect of optimisation, doctor and patient are integrated into a comprehensive control system (e.g. through service catalogues, billing procedures, etc.). Despite all the undeniable advantages of health care (prevention), there are dangers of a prior *standardisation of health* and quality of life through established target values (ideal weight, blood pressure values, cholesterol values, etc.), so that their concrete design is no longer at the individual disposal of doctor and patient. Here, conflicts between standardised medical action and individual patient preferences (§ 10) are to be expected more or less regularly.

5. **Institutionalisation**
   Medical action in everyday hospital and practice operations is overall subject to processes of institutionalisation, which are not only characterised by tendencies towards specialisation, standardisation and economisation (see above), but are also subject to tendencies towards increasing bureaucratisation and legalisation (see below). The personal *bond* and *responsibility* between doctor and patient is increasingly difficult. Medical action is becoming anonymous, as the person acting moves within formalised systems of action and is oriented there only to a specific institutional ethic (e.g. Wieland 1986, Sass 1991, Koerfer 1994, Woopen 2001, Pilnick, Dingwall 2011). The principal interchangeability of the subjects of action has the conse-

quence that they can hardly develop trust due to the lack of personal confidentiality, closeness and established acquaintance, as Jaspers already put it in a nutshell in the 1960s: "Powers intervene between doctor and patient, and they have to act in accordance with them. Trust from person to person is lost." (Jaspers 1958/86: 43). How *trust* can nevertheless be preserved or regained should interest us continuously and especially (§ 7, 10) under the aspect of a *dialogue-based* relationship between doctor and patient.

6. **Bureaucratisation**
   In the manifold forms of medical charts, questionnaires, doctor's letters, diagnosis codes, accounts, etc., which can develop a momentum of their own as a documentation system, there is a danger of bureaucratisation, which can lead to further standardisation and automation, for example in the form of expert systems (e.g. Dieckmann 1981, Ehlich 1993, Koerfer 1994, Ehlich 2020, 2022). As a result, communication between doctor and patient is itself increasingly *pre-formulated*, at best moving between communicative "guard rails" along dead-end paths. The "real" conversation, which in the sense of Martin Buber (1954/1986) must always be conducted in an open-ended way (§ 7, 10), turns into an exchange of punched fragments of communication in the sense of text modules of written communication, as it is standardised within and between institutions. Overall, the dialogue between doctor and patient is at risk of degenerating into an automated decision-making process.

7. **Legalisation**
   Medical action is justified according to a merely *legalistic* ethic, which in turn can increasingly encourage defensive medicine that threatens to lose itself in over-diagnosis and over-therapy (Taupitz 1987, Wolff 1989, Gigerenzer, Gray 2013). Often, only minimal standards are met (in the form of briefly annotated information sheets), which are intended to serve the legal (self-) protection of the actors, but which, under time constraints, can hardly meet the demand of an enlightened and informative medicine, which could enable the patient to participate in decision-making in a qualified manner (in the sense of *empowerment*) (§ 10).

8. Cooperativeness and interdisciplinarity

Despite or precisely because of all the restrictions (standardisation, specialisation, anonymisation, etc.), medical action is at the same time increasingly dependent on the cooperativeness of those involved, not only with the patient in medical decision-making (§ 10), but also with colleagues, and with these not only within the operating team in the operating theatre (Uhmann 2010), but also in the practice and on the ward, as well as in collegial communication within the team, in conferences, committees, at research congresses and vis-à-vis the public (Flin et al. 2016, BMBF 2017, Cracknell, Cooper 2018, St.Pierre, Hofinger 2020, NKLM 2021, Donaldson et al. 2021). In this context, cooperation does not only extend to one's own professional field of action, but requires interdisciplinarity, which does not only exist in the case of referral or consultation with neighbouring disciplines, but must also be sought with other professions from the health care system (nursing, psychologists, physiotherapists, social workers, pastoral care workers, etc.).

9. Democratisation

Processes of democratisation also in the health care system make patients appear to the doctor as "responsible" citizens with the right to information and self-determination, so that the *relationship* can prove more difficult compared to the traditionally "docile" patient (keyword: *compliance*) (§ 10). Problems arise here not primarily because of personal differences, animosities, inadequacies, etc. of the actors, but they are structurally conditioned, among other things because in a democratic society, the diversity of views and opinions remains protected for good reasons. This applies equally to the patient and the doctor, even if the patient's preference should, on balance, be "decisive" in case of doubt, as we will see in dialogical decision-making (§ 10).

10. Pluralism

In a democratic society characterised by socio-cultural diversity, conflicts of values between doctor and patient are both possible and justified, so that dissent remains permissible (§ 10). *Consensus* is not self-evident, but may have to be laboriously established, especially when it comes to intercultural communication among members of different cultures (§ 28). For the purpose of *understanding,* discursive procedures should be constitutive in the doctor-patient

> conversation, the outcome of which is in principle uncertain in the sense of a "genuine" conversation (Buber 1954/86: 296) (§ 7, 10). In the problematic case, the dissolution of the doctor-patient relationship is to be preferred to the continuation of an "unholy alliance".

We will take up some of these developmental tendencies in medicine again later, especially under the aspects of the *partnership-based* relationship in medical decision-making, in which not least conflicts between the patients' *lifeworld* and the *professional world* of the doctor must be managed (§ 10). Here, for example, conflicting tendencies of institutionalisation and bureaucratisation versus democracy and plurality come to the fore. In principle, there is a need for explanation above all with regard to the *relative* weightings with which the individual factors interact in medical action. For example, the tendencies towards *economisation* and *legalisation* may reinforce each other, insofar as overdiagnosis and overtherapy can be both financially profitable and help to reduce the legal problems of medical practice.

5.1.2 Institutional and individual acting

However, the reference to factual developments in practice is by no means intended to advocate the *normativity of the factual.* Rather, alternatives are under discussion that the medical profession as a whole can adopt. The individual doctor can more or less yield to or resist certain, sometimes contradictory, developmental tendencies, which results in certain room for manoeuvre that the doctor can use to individually shape the relationship with the patient.

However, it is doubtful that the doctor could escape the tendency towards institutionalisation as much as Wieland (1986) apparently still assumes (Box 5.1), who first declares medical action to be the "model of natural action in general" and then concludes:

Box 5.1	Doctor-patient relationship as an "uninfluenceable" archetype
This is why the relationship between doctor and patient could develop into the pattern of an interpersonal relationship of almost archetypal rank, which cannot be influenced by institutions in its core area.	

Wieland 1986: 54

The same reasoning could be used to elevate the educational actions of a teacher to the rank of "natural" actions, which would be immunised against institutionalisation. Conversely, the assumption of increasing institutionalisation does not have to deny the scope of action of institutional representatives such as teachers, judges and doctors (Koerfer 1994/2013, Brock, Meer 2004). Otherwise, principles of "teaching as dialogue" could apply neither to schools nor to universities if they were to be refuted solely by the prevailing reality of teaching (Ehlich 1981, Koerfer, Zeck 1983, Koerfer 1994/2013). As far as the core area of the doctor-patient relationship claimed by Wieland is concerned, the remaining scope of action of the doctor is to be described in empirical analyses, whose actions are not completely but partially restricted, not least by the scope of action that is to be granted to the patients in order to be able to develop health literacy on their part (Koerfer et al. 1994, Woopen 2001, Pilnick, Dingwall 2011, Gigerenzer, Gray 2013, Urstad et al. 2022). As far as the decision-making scope of the individual doctor is concerned, Pellegrino (1989) and Pellegrino, Thomasma (1988) have already emphasised the concrete alternative between the entrepreneurial and employee perspectives, under each of which doctors are exposed to specific, more or less directly mediated constraints of economisation, institutionalisation, legalisation, etc., which they can resist more or less successfully.

However, precisely because certain development trends in medicine as a whole are still in flux and the doctor's scope of action can by no means be regarded as completely and finally fixed, the current controversies are explained in a pronounced debate about the adequate model of the doctor-patient relationship and the principles of medical action in a posthippocratic medical ethics, which will be dealt with separately (§ 6, 7, 10). First of all, however, the changed *mortality spectrum* must be examined, to which the "doctor of the future" must adapt with a corresponding *competence profile.*

5.2 Mortality spectrum and medical competence profile

The teaching of *key competencies* has to be oriented above all to a changed *spectrum of diseases*, which is characterised by a shift from *acute* to *chronic* diseases and by an increase in *comorbidity* and *multimorbidity,* especially in advanced age. Accordingly, the German Council of Experts states in its report (2009) (Box 5.2) that there is a considerable need for action in health care provision.

Box 5.2 Need for action in health care

The German health care system is currently still strongly characterised by patterns of acute medicine and specialist care, which - also in the field of chronic diseases - has recorded significant progress (e.g. the decline in mortality from coronary heart disease, CHD). However, the problem of an ageing population (...) with an increasing number of chronic diseases requires a care approach that enables the most continuous (usually life-long) patient-oriented care possible.

German Council of Experts (Sachverständigenrat) 2009: 311

As also stated by the German Council of Experts, the number of chronic diseases is increasing along with the number of multiple diseases. This is especially the case in advanced age, which people and patients owe to medical progress: "With medical progress and demographic change, the number of chronically ill, multimorbid patients is increasing" (2009: 257). All in all, this changed spectrum of illnesses requires a different care concept with a medical competence profile suitable for it, with which doctors of all disciplines, with all the necessary specialisation, are prepared for the longer-term medical care of patients with chronic illnesses, multiple illnesses, health, physical and psychological complaints, limitations and impairments, especially in old age, etc. This does not only apply to the "doctors of the future", but already in the present, as will be made clear below.

5.2.1 Treatment of acute and chronic diseases

A significant development is the shift in focus from *acute* life-threatening diseases, which mainly included infectious diseases, to *chronic diseases,* which are experienced by patients as life-long diseases, especially in old age:

Box 5.3 Dominance of chronic diseases

While acute, mostly infectious diseases such as tuberculosis or diphtheria were still the most common cause of death in today's developed industrial nations at the beginning of the 20th century, chronic diseases such as diabetes and asthma or cancer dominate today.

German Council of Experts (Sachverständigenrat) 2009: 70

In the case of such chronic diseases, which can considerably reduce the patient's quality of life, long-term medical care is necessary, which poses special challenges for the doctor-patient relationship. Depending on the control result (e.g. "the values have worsened"), patients must be repeatedly motivated to cooperate in conversation in order to prevent or counteract *non-adherence,* such as in diabetes or coronary heart disease, where adherence to therapy can leave much to be desired (Albus 2010, Albus, Matthes 2014, Hermann-Lingen, Albus, Titscher 2022, Matthes, Albus 2014). In total, the economic costs of non-adherence in the USA alone are estimated at 100 billion dollars (O'Connor 2006), not to mention the economic follow-up costs and above all the prolongation of the individual suffering of patients.

Despite optimal treatment concepts, the doctor-patient relationship often involves setbacks or deterioration of the patient's condition, which are not only due to the patient's incorrect medication, but also to their unwillingness to change their *risky lifestyle* (poor diet, lack of exercise, nicotine and alcohol abuse) (§ 29). In addition, it should be considered that especially patients with a low educational status are increasingly affected by the health consequences of such risky lifestyles, as this was once again impressively proven in recent studies (Brähler et al. 2012, Rapp, Klein 2020).

Regardless of this connection between *education* and *health,* every doctor knows from his or her own experience how difficult it is to counter certain "bad habits" of patients. Here, frustrations of the interlocutors are to be expected on both sides of the conversation, which require a high level of professional responsibility and tolerance from the doctor in communicative dealings with these patients. They are often experienced as "difficult" patients (§ 34), whom the doctors then in turn meet more or less consciously with rejection, so that a maladaptive "vicious circle" can result here, leading to a further deterioration in the health of these patients.

5.2.2 Person-focused treatment of multimorbid patients

The quality of life of patients with physical (chronic) diseases can often be limited by *comorbidity* (anxiety, depression) (Schüßler et al. 2017), which is not infrequently misjudged and remains untreated for too long (§ 29). The doctor’s actions are then entirely focused on the treatment of a chronic disease (e.g. diabetes), and the doctor may fail to recognise that a lack of adherence to therapy is due to a decline in self-care on the part of the depressed patient (§ 29) (Kruse et al. 2006, Kulzer et al. 2023). In view of the *high prevalence of mental illnesses* and their effects on the health of chronically ill patients, the German Council of Experts (2009) (Box 5.4) therefore calls for their greater consideration already in the measurement of multimorbidity.

Box 5.4 Psychological comorbidity

> The pronounced effect on the state of health becomes particularly clear in a recent study by the World Health Organisation (WHO) on the prevalence and significance of depression, which was carried out in 60 countries. According to this study, 9.3 to 23% of patients with at least one chronic disease have depression as a comorbidity. This is the most important factor compared to other chronic diseases regarding the deterioration of the patients' health fate (...) Mental illnesses must consequently definitely be included in the measurement of multimorbidity.

German Council of Experts (Sachverständigenrat) 2009: 252

Despite the high prevalence and significance of physical and/or mental multiple illnesses, there is not only a lack of sufficient medical *care for patients*, but also of evidence-based *guidelines,* which only in exceptional cases refer to two or more illnesses in combination. Here, there is a need for improvement not only in research and the professional societies, which must cooperate interdisciplinarily in the development of recommendations, but also in medical education and further training, as the German Council of Experts (Sachverständigenrat 2009: 256ff) also urges. Likewise, the treatment of *multimorbidity* is often insufficient

(Box 5.5), as it can also occur independently of an underlying disease and especially in older patients.

Box 5.5 Definition and spectrum of multimorbidity

Multimorbidity is the presence of several, recurring, chronic or acute diseases or symptoms within a person at the same time, whereby these are independent of an underlying disease (index disease), in contrast to comorbidity (...) In multimorbidity, a complex structure with several individual diseases is present. In this context, multimorbidity is more than the sum of the individual diseases. For the assessment of the disease burden for the patient due to several simultaneously existing diseases, the disease pattern, the development over time as well as social factors are important (...) In addition, emergent syndromes (such as incontinence, confusion, risk of falls and complex pain conditions) occur and functional limitations and disabilities arise for the patient, which affect his or her ability to cope with everyday life.

German Council of Experts (Sachverständigenrat) 2009: 251

If there is no acute case of treatment (e.g. after a fall with a fracture), in which evidence may be given due to situational and cognitive circumstances, all these diseases or syndromes must first be *explored* with the patient in *conversation,* for example by asking about mobility in general or the certainty with which the patient moves through everyday life (orientation, tendency to fall, dizziness, etc.) or about adherence to therapy with medication, which could be limited by "forgetfulness". Under certain circumstances, reduced adherence to therapy is not due to a *lack of motivation* on the part of the patient (§ 29), but to *cognitive deficits,* which can affect older patients in particular (§ 37).

Sometimes the problems of communication between doctor and patient are also quite "banal" in nature, when communication with older patients is impaired by *hearing loss* (Egbert, Deppermann 2012). Hearing loss can also go unnoticed by the doctor precisely because the patient tries to deny and conceal his or her impairment. Similar *denial behaviour* (as a form of defence) is of course to be expected with other impairments that affect the self-esteem of older people in particular (e.g. incontinence). Here, in a *tangential discussion* (see below), care must be taken to deal *gently* but firmly with "sensitive issues" (§ 21.6), which often include not only problems of digestion and excretion but also impairments in sexuality.

With the change in the morbidity spectrum, a change in the treatment perspective is necessary at the same time, in which doctors can no longer focus their attention on individual diseases. From the increase in multiple illnesses, especially in old age, the German Council of Experts (2009) (Box 5.6) derives the demand to turn away from a *disease-focused* and towards a *person-focused* treatment:

Box 5.6	Person-focused treatment focus
In the case of patients with multiple illnesses and especially in the case of multimorbidity typical of geriatrics, the focus of treatment should no longer be disease-focused but person-focused.	

German Council of Experts (Sachverständigenrat) 2009: 251

If this shift to person-focused care is to be implemented in practice, the doctor of the future must not only explore the details more thoroughly (symptoms of illness), but also work out the extent of the patient's "overall burden of illness" as a person in everyday life as well as his or her remaining *coping resources* (§ 5.2.4). Only in this way will the doctor be able to recognise the necessary diagnostic, therapeutic or nursing measures (e.g. geriatric consultation, social services) if necessary and discuss these measures with the patient or his or her relatives and, if necessary, initiate them and finally accompany them in a controlling and supportive manner in agreement with all those involved.

5.2.3 Tangential communication for somatoform disorders

Furthermore, the doctor must deal with patients who periodically or permanently suffer from *functional* or *somatoform disorders* without objectifiable organic findings (Ronel et al. 2007, Rudolf 2008, Henningsen 2007, Lahmann et al. 2010, Hausteiner-Wiehle et al. 2013, Hausteiner-Wiehle, Henningsen 2015). Already from an epidemiological point of view, they represent a relevant group of patients, although the data on prevalence rates vary: they are given as 25-35% for primary care. This group of patients generally poses a particular clinical challenge for the doctor (Box 5.7).

Box 5.7 Somatoform disorders

Somatoform disorders are characterised by persistent or frequently recurring bodily complaints that are subjectively experienced as impairing and for which no sufficient organ-medical explanation in the sense of a causal organ pathology can be found, even after appropriate somatic diagnosis. Somatoform disorders are a widespread phenomenon worldwide and represent a clinical challenge in almost all areas of medicine (...) The clinical picture causes a disproportionate, dysfunctional and, above all, cost-intensive utilisation of the health care system and is accompanied by an accumulation of anxiety, depressive or personality disorders, especially in severe or chronic courses.

Lahmann et al. 2010: 453

Dealing with these patients often proves difficult, which already manifests itself in frequent therapy interruptions and changes of doctor ("doctor hopping"). The patients continue to be guided by their "subjective theory of illness" (§ 21, 29), according to which their massively and threateningly experienced complaints (must) have an "organic cause", and react with fierce resistance if this is called into doubt. Often they have had an "odyssey" of visits to doctors and examinations, which were also concluded with an often "mortifying" diagnosis message ("you have nothing"), which increases their disappointment or anger because they do not feel taken seriously as a person with their suffering.

In order to prevent patients with somatoform disorders from breaking off their relationship with the doctor at an early stage, a special way of shaping the relationship and communicating with these patients has proven to be effective. With this type of conversation, the doctor tries to successively approach the patient's attitudes, i.e. his or her beliefs, expectations, hopes, fears. With indirect and implicit verbal interventions, the doctor can succeed in "bringing up" the issues in question, which are initially *taboo subjects for the patient*, gradually or even in a roundabout way. This applies especially to emotionally charged topics where the doctor has to "listen" to implicit "hints" from patients that can easily be "overheard".

This communicative phenomenon ("voiced but unheard") has been investigated by the research group around Salmon et al. (2004, 2007), who in particular studied indirect communication ("psychological cues") in patients with "medically unexplained symptoms" (MUS). Using different terminology, which continues to be inconsistent (Burbaum et al. 2010, Creed et al. 2010, Klaus et al. 2012, Hausteiner-Wiehle, Henningsen 2015), a sensitive approach to patients is recommended here, whose complaints must first be acknowledged before further medical interventions to promote understanding and processing of the illness can take effect.

Before interventions of a "higher" type ("clarifications") can be sensibly placed, the medical art of *active, empathic listening* is required (§ 20, 21), which the doctor should master in general, but especially in relation to patients with whom problems in emotional access can already be anticipated from the clinical picture. By conducting the conversation *tangentially* (§ 17.3, 32), patients should be "touched", but their current self-image should not be "disturbed" in such a way that they are unnecessarily led to defensive processes and thus the therapeutic success is obstructed or even made more difficult.

Guidelines have now been developed on "Dealing with patients with non-specific, functional and somatoform bodily complaints" (Hausteiner-Wiehle et al. 2013, AWMF (ed.) 2012), which also contain concrete *practical tips with examples of formulation.* We have also compiled a collection of anchor examples of conversational maxims in the form of a *manual on medical conversation* (2010) (§ 1, 3, 17), which, in line with the guidelines, will be supplemented by empirical examples (§ 18-23) from an extensive corpus of conversations.

5.2.4 Pathogenetic and salutogenetic perspectives

With the diagnostic and therapeutic possibilities of medicine, on the one hand the boundaries of what can be treated are shifting, and on the other hand the differences between "disease-causing" and "health-promoting" factors are coming more into focus. It is no coincidence that the traditional *pathogenetic* concept in medicine, which is based on a dichotomous pair of concepts of *health* and *disease,* has now been supplemented by a *salutogenetic concept,* which assumes a health-disease continuum and takes into account the salutary resources that move the organism towards the health pole in the continuum (cf. Antonowsky 1987, 1997, Köhle, Obliers, Faber 1994, Ventegodt et al. 2005, Meyer-Abich 2010, Petzold, Bahrs 2020, Bahrs 2022, Rojatz et al. 2022, Mittelmark et al. (2022). The hypothetical question to the patient is no longer only about his or her deficits ("Where are you lacking?"), but also about his or her remaining abilities ("What can you do?"), ("What do you dare to do?") (§ 22.2). These topics can also rarely be asked directly, as hypothetically assumed here, but must be developed appropriately in the context of the conversation.

In order to find out about patients' shortcomings and losses as well as their health resources, a questioning technique other than an exclusively *interrogative* one is needed. Certain life experiences of patients and their self-representations can hardly be explored according to the question-answer pattern, but can best be conveyed in independent patient narratives, for which, however, the doctor has to create space conversationally through appropriate stimulation ("narrative invitations") (§ 9). The fact that in this sense a *biographical narrative* anamnesis is more effective and efficient than an interrogative interview technique will also be shown in detail in a series of interview analyses (§ 19, 20).

5.2.5 Preventive to palliative treatment spectrum

Certainly, the *curative* function of medical action remains a central function of medicine. In view of the changed spectrum of diseases and the growing public attention to the necessities and possibilities of preventive medicine, early detection or prevention is already one of the tasks of paediatric and adolescent medicine (Bürgin, Rost 2011, Resch 2017), the development of which is given special emphasis by the German Council of Experts (Sachverständigenrat) (2009). Here, among other aspects, psychosocial problems in the family are to be recognised at an early stage in order to counter the consequences of separation or domestic violence, for example.

After all, beyond the traditional *curative* function in the narrower sense, the doctor increasingly must perform *rehabilitative* and, not least because of the socio-demographic development of our society, *geriatric* and increasingly *palliative* care functions, which require special communicative competences (Kissane et al. 2011, Obliers, Köhle 2017, Köhle 2017, Söllner, Keller 2017, Coussios et al. 2019, Buck 2022). In particular, communication with these patients used to be less of a focus of medical action; it was often delegated (to relatives and nursing). Chairs of palliative medicine are still not the rule, but their increase illustrates this development trend, according to which certain patient groups can no longer be adequately cared for in a narrower biomedical sense.

The emergence of so-called "hyphen" disciplines, such as *psychocardiology* (Albus et al. 2014, Herrmann-Lingen, Albus, Titscher 2022) or *psychooncology* (Tschuschke 2011, Söllner, Keller 2017) or also *psychoneuroendocrinology (*Fries et al. 2017), etc., which are more strongly oriented towards a holistic model of explanation and care, as is claimed with a *biopsychosocial* approach to understanding (§ 4), points in the same direction. The holistic treatment perspective of a multitude of diseases is particularly demanded in family practice, which we will address separately (§ 25) with empirical practical examples.

5.3 Health and disease concepts

With the broad treatment spectrum of the doctor, ranging from preventive health promotion to palliative care for terminally ill patients (§ 38), the question arises of health and disease concepts on which doctors and patients - despite all individual differences - must agree together to a certain extent in their communication if they are to act successfully together.

In the socio-political as well as medical(-ethical) discussion, it remains controversial what is actually in need of treatment or even worthy of treatment. In this discussion, more or less broad or narrow concepts of health or disease are used.

5.3.1 The broad notion of 'well-being'

A very broad, often quoted but rarely unreservedly accepted concept of health and disease was developed by the World Health Organisation (WHO) more than six decades ago (Box 5.8). The main aim is to distinguish it from a restrictive concept of health, which is characterised solely by the absence of disease and infirmity:

Box 5.8	Well-being according to the WHO
Health is the state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.	

WHO 1948, quoted on Anschütz 1988: 100

On the one hand, this definition of health is seen positively because of its comprehensive claim, but on the other hand it is criticised precisely because of this. First of all, the WHO concept is appreciated for taking into account all three dimensions of health, namely the *physical, mental* and *social* dimension, which can also benefit downstream concepts such as *quality of life* (Box 5.9):

Box 5.9	Health-related quality of life

However, it is widely accepted, the idea contained in this term, that health consists of three components: a physical, a psychological and a social one. These three components are therefore also often used to further narrow down the concept of health-related quality of life. Health-related quality of life is accordingly reflected in how satisfied people are with their physical, mental and social state of health, or - in other words - how they rate these aspects of their health.

Konerding, Schell 2001: 139

As we have already seen, the three-dimensional concept of health and illness is in line with the understanding of a *biopsychosocial* medicine (§ 4), which is based on a comprehensive concept of knowledge and treatment. Despite all objective collection of disease-relevant data, the focus is on the subjective experience of disease of the patient, who, as a sick person, should obviously be able to make the best judgement about his or her own health.

5.3.1 Criticism and application problems

Criticism of the WHO's broad concept of health is often associated with an excessive sense of entitlement to which individual patients might be excessively subject. The first criticism of the WHO's definition of health is that the criteria are set so high that almost everyone would eventually be ill. This criticism usually culminates in an accusation of illusion, insofar as the demands of the individual on him or herself and on health care associated with this broad definition of health are unrealistic because unrealisable (Anschütz 1988, Konerding, Schell 2001). Anschütz (1988) (Box 5.10), for example, considers the WHO's definition of health to be both "philistine" and "naive", not least because, in view of the high expectations of happiness and health in the Western world, ageing would logically be regarded as a disease.

Box 5.10 Criticism of the high demand for happiness and health

The high demand for happiness and health in the western world is also promoted by the public suggestion of what is so-called feasible, by a pronounced striving for salvation, truth, happiness, power and wealth. Here, an aspiration is taken to an extreme that can no longer be realised. And this demand is so omnipresent and seems so self-evident that no one can completely free himself from it. Today's man apparently only feels socially balanced when he can travel abroad, is very mobile on motorways (...) when he euphorizes his restless mind with alcohol or even sleeping pills and when his life is socially, professionally, familially ordered as it corresponds to his ideas. Medicine has largely adapted to this demand, the surgeon by lifting disturbing wrinkles, the internist by the tablet for all situations in life (...) In reality, sooner or later everyone has to cope with some infirmity himself by adapting himself in the sense of self-education to his diminishing capacity, which occurs at the latest in old age. All definitions of health which focus on well-being and the preservation of physical integrity and adaptability must regard ageing as a disease.

Anschütz 1988: 100-101

The criticism often seems just as exaggerated as the criticised WHO health concept. Although Anschütz rightly describes possible extremes, the individual can be overtaxed with the suggested "self-education" to adapt to the age-related decline in performance and become a patient precisely because of this overtaxing. Here again, the doctor can help to find the individually appropriate balance "between demand and reality".

However, the problem of the patient's *well-being* as the primary goal of treatment remains a problem both in research and in the practice of care. The problem is by no means solved with the mere dichotomy of *objectivity* and *subjectivity,* nor with traditional distinctions between *disease* and *illness*, *symptom* and *sign* (signs of illness) or *findings* and *condition* (experience). According to von Uexküll and Wesiack (1991), these terms only distinguish analytical aspects that are to be integrated in a *biopsychosocial medicine* (§ 4).

However, this also involves the "justification" of medical treatment goals in the "narrower" sense (e.g. the "medical" attitude of a diabetic), which have their meaning only in the hierarchy of so-called higher-order *endpoints* (§ 8), which in turn ultimately brings into play the "quality of life" of the patient, who has his or her personal idea of a "good" life, which he or she may subjectively experience as limited, etc.

In his current critique of definitions of illness and health as well as research methods in medicine and psychology, Kagan (2012) laments the lack of context-sensitive studies on concepts such as *well-being* or *happiness,* whose ambiguities can only be investigated and understood in a culture-, history-, language-, class-, gender- and age-specific manner. Inasmuch as, according to Kagan (2012) (Box 5.11), one cannot in principle escape the *ambiguity* of supposedly similar self-disclosures by individuals, one must not rely on the first best verbalisations of interviewed persons but must systematically question them in the respective context and classify them appropriately in the respectively valid semantic network of the interviewees.

Box 5.11 Ambiguity of well-being

The meaning of life satisfaction, or well-being, does not escape this ambiguity. Most adults who have sufficient food and shelter and are free of serious chronic illness rely on a judgment of the ethical quality of their lives when they answer the few questions that define well-being: "How satisfied are you with your life?" "Have you gotten most of things that you wanted in life?" and "All things considered, how satisfied are you with your life these days?" The judgments of individuals from diverse societies would change only a little if the question were "All things considered, have you lived the life of a good person?" However, because the semantic networks for good vary across historical eras and cultural settings, the meaning of a low, moderate, or high level of well-being must also vary. Put simply, individuals who report the same level of well-being could have behaved in different ways, achieved different goals, held different values, and experienced different feelings over their lifetimes.

Kagan 2012: 78f

The methodical-systematic research of such concepts as *well-being* and *happiness* is one thing, the communication with individual patients about their treatment goals that are significant in their *lifeworld* is another. The problem of the *ambiguity* of what the patient *formulates* as his or her *final* interest in the medical treatment (§ 8.4) must be faced by the doctor in communication with his or her individual patient. In communicative exchange, the two interlocutors must alternately assure themselves that they are "pulling in the same direction" when, for example, they seek to improve the patient's *quality of life,* which is an established concept in medicine with proven measuring instruments (Bellebaum, Barheier 1994, Konerding, Schell 2001, Pukrop 2003, Herzberg, Brähler 2017, Schübel 2020), as the primary *guiding goal* of treatment, to which other treatment goals must be subordinated. We will further explore this problem of determining (hierarchies of) so-called *endpoints* of medical action both systematically (§ 8) and on the basis of empirical cases (§ 21-22), in which, for example, the concern of a diabetes patient who sees his or her *quality of life* considerably *improved* by a "switch from syringe to pump" is at stake.

Under the special aspect of *palliative* medicine (§ 38) (Kissane et al. 2011, Obliers, Köhle 2017, Köhle 2017, Söllner, Keller 2017), the problem is dealt with that patients often still undergo a so-called *change in values,* especially at their expected end of life, which they themselves probably recognise or allow to be recognised in this form for the first time in communication with their carers. In this case, it is apparently only in the conversation at the end of life that the patients realise what was or has become important to them in life. This is a further methodological indication that the doctor should not follow the first self-declarations of patients by means of *questioning*, but if necessary must repeatedly seek dialogue in order to reduce the ambiguities and ambivalences of the patient, even if they cannot in principle be circumvented, in such a way that a certain security arises for both partners that they are acting in the recognisable interests of the patient, which should at least have intersubjective "validity" until revoked in the "consultation hour".

5.4 Evidence-based medicine and guidelines

Although individual care remains the supreme principle of medical action, the patient also has a right to optimal treatment "according to all the rules of the art". However, these can also change with progress, so that both actors may have to adjust their actions to current standards in the sense of "evidence-based medicine" (EBM). Before we come back to this systematically (§ 10) and empirically with practical examples (§ 22), we will describe the scope for medical action that remains for the individual doctor in the individual case with his or her individual patient, if joint decisions are nevertheless to be made *evidence-based.*

5.4.1 Guidelines and decision-making autonomy

First of all, the concept of evidence does not refer to subjective experiential certainties of individual doctors, but rather to evidence in a sense that can be objectified through studies, as explicitly emphasised by Henningsen, Rudolf (2000) (Box 5.12).

Box 5.12 Objectifiable evidence in the plural

EBM does not refer to "evidence" in the singular, as the subjective experience of a coherent connection, but, on the contrary, to evidence in the plural, in the sense of objectifiable evidence, clues or proof.

Henningsen, Rudolf 2000: 367

For a good two decades, first in the English-speaking world (Canada, USA, UK) and then in Germany, guidelines on medical care have been developed and applied to systematically summarise and communicate standards, as they have always been aimed at, in order to achieve health goals relevant to patients (Bollschweiler 2001, Redaelli et al. 2001, Schmacke 2006, Sachverständigenrat 2009, Kopp 2011, Farin et al. 2011, Charles et al. 2011, Smith 2013, Dietsche 2018). Evidence-based guidelines serve to ensure the quality of medical practice (Box 5.13), which should ultimately benefit patients.

Box 5.13 Function of guidelines

The primary aim of guidelines is to improve medical care by communicating knowledge. In this context, guideline authors have the task of presenting the state of knowledge in terms of the best available scientific evidence on specific issues.

- to be explicitly stated,
- to be evaluated under methodological and clinical aspects,
- clarify opposing points of view,
- weighing up the benefits and harms,
- consideration of the needs and attitudes of the patients,
- define the current procedure of the election (...)

Concrete recommendations for action in guidelines should therefore be based on a benefit assessment of the respective interventions tested from a methodological, clinical and patient perspective.

Kopp 2011: 160

In terms of their claim, guidelines are always *recommendations* that are not to be followed schematically but are to be taken into account in concrete treatment situations with the inclusion of individual patient interests. According to their self-conception, guidelines should therefore by no means be (mis)understood as "cookbook medicine" or "prescriptive medicine" (partly still critical: Redaelli et al. 2001, Schmacke 2006, Sachverständigenrat 2009: 256f, Henry et al. 2008, Charles et al. 2011, Smith 2013, Dietsche 2018). Rather, the primacy of the clinical judgement of the doctor remains, which in principle cannot be "overruled" by guidelines, as this is also specifically emphasised by the German Council of Experts (2009) (Box 5.14).

Box 5.14 Primacy of medical judgement

Evidence-based guidelines are systematically developed action and decision corridors for patients and health care providers. They are intended to lead to individually appropriate health care and to transparency (...) However, therapy according to evidence-based guidelines implies that they can or must be deviated from on an individual basis if the clinical decision, taking into account the overall situation, requires this or if patient preference opposes a therapy. Therefore, good guidelines should not take on the character of "prescriptive medicine" (...) and do not represent a threat to the autonomy of the therapeutically active physician's own innovative potential and intellectual capacity for development. They are tools for improving the quality of treatment. In this context, guidelines never "overrule" the doctor's judgement in the treatment of the individual patient, especially since the doctor must take into account the patient's preference in addition to his assessment of the particular conditions of the individual case.

German Council of Experts (Sachverständigenrat) 2009: 256f

Insofar as the decision-making autonomy can be exercised in the individual case by both dialogue partners (doctor, patient) in their own way (§10), the fears of incapacitation by higher-ranking authorities, whose guidelines would have to be followed without further ado, seem unfounded. On the contrary, both parties to the interaction could benefit equally from evidence-based guidelines. However, despite the development of numerous guidelines at a high level (Kopp 2011, Farin et al. 2011), implementation in practice is still considered insufficient, for a number of reasons.

5.4.2 Problems of implementation in practice

A variety of reasons are cited as barriers to the implementation of guidelines, including above all the lack of practical orientation, the scientific information overload and practical documentation burden, as well as the continued feared loss of autonomy of doctors and their patients, which has already been critically compiled overall by the German Council of Experts (2009: 257 ff) (Box 5.15).

Box 5.15 Reasons for the insufficient implementation

It can be assumed that the implementation of the medical guidelines is still insufficient. The reasons are manifold:

- Lack of practical orientation, only science-oriented and therefore difficult to apply (guidelines as dialogue between researchers).
- Service providers see the guidelines as limiting their autonomy, as paternalism.
- Doctors or other health professionals do not agree with the opinion of the guideline authors (...)
- The guideline recommendations run counter to patient preferences.
- Doctors or other health professionals decide to ignore guidelines due to high patient turnover, time constraints, "inundation" with scientific information, among others.

German Council of Experts (Sachverständigenrat) 2009: 257

To overcome these problems, a number of implementation strategies are discussed, which should be used in combination if possible. The Council of Experts considers these to include: *Education* (basic, further and advanced training; teach the teacher); *feedback* (quality circles); *participation* of the target groups; *financial incentives*, etc. The *evaluation* should, on the one hand, examine the usual criteria (achievement of treatment goals, reduction of hospital stays, referral practice), but also take into account parameters such as patient satisfaction, adherence and quality of life, to which we will return in detail in the formulation of *therapeutic goals of* medical action (§ 8).

Misinformation, prejudice, reluctance and resistance of doctors to the use of guidelines are only one problem, the lack of specific guidelines on specific clinical pictures is another. In particular, the German Council of Experts (2009) complains about deficits in the development of guidelines for the treatment of *multimorbid* patients: "There are very few guidelines that refer to patients with multiple diseases" (259). The dilemma is that when the need arises, a satisfactory solution cannot be achieved simply by adding up several guidelines. Again, the whole is greater than the sum of its parts (Box 5.16).

Box 5.16 Desiderata for guidelines, especially on multimorbidity

As multimorbidity is more than the sum of the individual conditions, guidelines developed for these patients are not the sum of the guidelines for the individual conditions. They must set treatment priorities, be adapted to the patient's overall condition, and take into account the risk of interactions that increases with each drug. In particular, they must follow a patient-centred rather than a disease-centred approach and take into account the life expectancy and the very individual situation of the patient. They thus help to make decisions, but by no means take them away from the doctor given the complexity of the situation.

German Council of Experts (Sachverständigenrat) 2009: 261

Due to the complexity of the situation, guidelines can soon reach their limits, especially in the case of patients with multiple illnesses, for whom the individual competence of the doctor is still required to make use of guidelines as decision-making aids, which leave sufficient scope for decision-making in each case. However, the scope for decision-making and action is not only *granted*, but at the same time *imposed* on the individual doctors. Their competence will be challenged especially in complex treatment situations, in which they can only refer to *a* certain "guideline-compliant" recommendation to a limited extent. Smith (2013) (Box 5.17) describes what he calls the "gap between evidence and practice", which can certainly be generalised beyond the UK, with a drastic example that will be reproduced here in detail because of its illustrativeness.

Box 5.17 "The gap between evidence and practice"

Evidence-based guidelines also proliferated explosively. However, it is unclear whether and how much this information processing has ultimately advanced evidence-based action. Doctors also seem to make little use of these service programmes when treating patients. One reason may be that it is difficult to apply evidence to individual patients because the questions that come up in practice are usually not "What is the best treatment for a patient with atrial fibrillation?" but rather "What is the best course of action for a 75-year-old woman who has atrial fibrillation, chronic obstructive pulmonary disease, mild dementia, drinks large amounts of alcohol, smokes, lives alone and only sees the doctor when her son pressures her accordingly?" In reality, the questions in daily practice are much more often like the latter and not the former (...). Consequently, it is no wonder that evidence-based interventions are difficult to apply.

Smith 2013: 287

However justified the criticism may be in principle, "the baby should not be thrown out with the bathwater". In the present case, too, whose complex problems are plausibly illustrated, knowledge of disease-specific, e.g. psychocardiological guidelines can certainly be useful (Ladwig et al. 2013), even if the patient's further treatment can certainly not be reduced to "atrial fibrillation". Such a biomedical reduction had already proven to be of little use in the case of the "heart" problem of a patient whose complex medical history had been discussed in detail with von Uexküll and Wesiack (1991, 2011) from a biopsychosocial perspective of knowledge, communication and treatment (§ 4). In such complex cases, the doctor's *fitting competence* is particularly challenged, which also consists in the selective use of relevant guidelines that are to be applied flexibly.

5.4.3 Medical fitting competence

If one sums up the case (hypothetically) assumed by Smith, the (assumed) doctor can at the same time be credited with a good conduct of the conversation, because a lot of biopsychosocial "data" was already collected during the anamnesis. The doctor was evidently able to explore the patient's *co-morbidity* (including dementia), her specific *risk factors* (alcohol, smoking, "living alone") and her overall *maladaptive* behaviour (§ 29). The patient's self-harm consists not only in her alcohol and nicotine abuse, but also in the patient's *resistance* (denial), who only visits the doctor under pressure from her son.

In this complex "mixed situation", the doctor has to choose a relevance hierarchy of decisions in consultation with the patient, which also has to be done with evidence-based prioritisation (§ 10). It may be that, based on current findings, cardiological treatment has priority even before "sensitive" issues such as the alcohol or nicotine problem can be explored in depth (§ 21.6, 22.2). Accordingly, certain problems must remain subordinate (treated) so that the more urgent tasks do not fall victim to increased defence, etc.

Even in similarly complex cases, the doctor cannot simply refer to the *one* "guideline-compliant" recommendation, but must - as in other areas of life and work - flexibly meet any conflicting maxims of action. This flexibility is also expected in dealing with conflicting maxims of discussion, when doctors have to decide again and again in a complex discussion situation, for example, between a *confrontational* or *tangential* conduct of the discussion (§ 3, 17, 32). This challenge has already been discussed (§ 5.2.3) using the example of dealing with somatoform disorders, to which the doctor must adapt with *clinical* and *communicative competence* in order to do justice to the specific clinical picture of these patients.

Making decisions appropriate to the situation, both in *communicative* action (*confrontational* versus *tangential* discussion) and in *instrumental* action (surgery versus conservative measures) (§ 7, 8), requires throughout a doctor's *fitting competence* (§ 3.3, 17), which is to be acquired through training and further education and ultimately to be further developed through many years of professional experience.

This medical fitting competence also includes the selection and application of "guideline-based" recommendations appropriate to the situation. As the term "*recommendation"* already suggests, it can also be rejected after "careful" consideration. Taking guidelines into account does not mean following them as if they were a set pattern. As the Council of Experts has already pointed out (Box. 5.14), medical autonomy is in no way restricted by guidelines, which in their function as a decision-making aid should not be able to "overrule" medical judgement and competence to act anyway. Accordingly, the Council of Experts (Sachverständigenrat) (2009) comes to an overall definition of the function of guidelines, according to which, despite all the necessity and possibility of standardisation and facilitation of action for the doctor, the boundaries of guidelines remain more or less fluid, so that, especially in the case of multiple illnesses, they at best open up "corridors of action" (Box 5.18) for the doctor.

Box 5.18 Simple decision trees and action corridors

This means that one of the goals of guidelines, the reduction of variation in diagnosis and therapy, can only be achieved to a limited extent, since the overall burden of disease, life expectancy and social structures in this patient group are very different and the medical and nursing approach must be adapted to this. Nevertheless, corridors of action are important, even if they do not lead to simple decision trees, but rather provide the doctor with the instruments and criteria that lead to a decision together with the patient and others involved in the care (such as nurses, physiotherapists, relatives).

German Council of Experts (Sachverständigenrat) 2009: 262

Precisely because guidelines cannot be used as "simple decision trees" in practice, their individual application in individual cases by the treating doctor remains indispensable. As we will show below, first theoretically and then on the basis of empirical cases, *decision paths* are first and foremost *communication paths* that doctors must follow in discussion with their patient (§ 8). On these communication paths, the full complexity of the patient's *overall burden of disease* must first be unfolded thematically before it can be reduced, if necessary.

The person-oriented approach is to be preferred to the *disease-oriented* approach, if only to be able to counteract a narrow focus on a "first-best" individual disease from the outset. Especially at the beginning, the discussion with the patient should be "open-ended" (in the sense of Buber 1954/86: 296) in all directions (§ 7.5) and nothing should be ruled out prematurely.

But also in the further treatment process, *communicative* review procedures must be incorporated again and again, which allow for revisions or modifications of decisions once they have been made, if this is factually (still) possible. Especially in the case of uncertain courses of the disease, new *treatment priorities* may arise that have to be redefined in communicative negotiation processes. It must also be taken into account that patient preferences can change during the course of the disease and treatment, which in turn can result in new communication paths with new decisions (§ 8, 10, 22), which must be coordinated between doctor and patient in discussion in order to reach a sustainable consensus for further treatment.

5.5 Further information

Through the cross-references to subsequent chapters, indications of the resumption of specific topics had already been given, for which further literature is then cited, for example on *Shared Decision Making* (SDM) (§ 10). Further literature references, for example on tangential conversation in somatoform disorders, are given in specific chapters both in theory and with practical examples (§ 17, 32). Questions on co-morbidity or multimorbidity of patients are discussed throughout the practical part and specifically under the aspect of "communication with the chronically physically ill" (§ 29).

Of the literature already cited above, the following works should be referred to again as examples for selected aspects: The early works of the „Murrhardter Kreis“ (1995) and the monographs by Dörner (2001) and Troschke (2004) as well as the volume by Simon (2005), which brings together contributions from various disciplines (internal medicine, urology, surgery, dermatology, etc.), are suitable as an introduction to the discussion on the ideal image of the "doctor of the future". Also relevant are the contributions on the "good doctor from an interdisciplinary perspective" and on the "doctor-patient relationship in modern medicine" in the two volumes by Witt (2010) and Deter (2010). For specific questions and issues in health communication and health literacy development, please refer to: Schorr (ed.) 2014, Hehlmann 2018, Lenartz et al. 2020. A critical review on problems of defining and measuring health literacy is given by Urstad et al. 2022. For a salutogenetic approach in medicine, please refer to the handbook by Mittelmark et al. 2022.

An informative and thoroughly critical overview of the development of the health care system and the need for reform is provided by the German Council of Experts (Sachverständigenrat) (2009), while the still current desiderata are formulated in the BMBF's "Masterplan Medizinstudium 2020" (2017). The programmatic book by Gigerenzer, Gray (eds.) 2011/2013 has not lost its topicality („Better doctors, better patients, better decisions: Envisioning health care 2020"). A specific programmatic draft ("Rethinking Medical Education") is given there by Davis (2011/2013), which particularly promotes interdisciplinary, lifelong learning, including in the workplace.

For critical overviews of the state of research on the development and communication of evidence-based medicine and on the guideline discussion, reference is made to the volumes by Lauterbach, Schrappe (eds.) (2001) and Hensen, Stamer (eds.) (2018) as well as to the articles by Kopp (2011), Farin et al. (2011), Donner-Banzhoff et al. (2011/2013) and Smith (2011/2013), who describes the "gap between evidence and practice" particularly critically. A selection of German guidelines is given by Hausteiner-Wiehle, Henningsen (2015); see also, for example, the many guidelines of the German Society for General Practice and Family Medicine (e.g. DEGAM 2022 on the anamnestic initial interview).

Specific (German and English) literature on guidelines/manuals for (the teaching of) medical communication (for a period of more than 50 years) is exemplified by: Morgan, Engel 1969/77, Froelich, Bishop 1973, Adler, Hemmeler 1989, Dickson et al. 1991, Coulehan, Block 1992, Buckman, Kason 1992/94, Geisler 1992, Lipkin, Putnam, Lazare et al. 1995, Smith et al. 2000, Launer 2002, Platt, Gordon 2004, Kurtz, Silverman, Draper 1998/2005, Veldhuijzen et al. 2007, Menz, Lalouschek, Gstettner 2008, Schweickhardt, Fritzsche 2009, Parrott, Crook 2011, Veldhuijzen et al. 2013, Silverman, Kurtz, Draper 2013, Cole, Bird 2014, Ärztekammer Nordrhein 2015, Hammersen et al. 2016, Brown et al. 2016, Cooper, Frain 2018, Koerfer, Albus 2018, Jünger 2018, Coussios et al. 2019, Lloyd, Bor, Noble 2019, Simpson, McDowell 2020, DEGAM 2022, Herrmann-Lingen, Albus, Titscher 2022, who give a "practical guide for doctors and psychologists" on general anamnesis taking and specifically also on psychocardiological interviewing.

On the specific problem of (measuring) quality of life and health, beyond the literature already mentioned (Bellebaum, Barheier 1994, Konerding, Schell 2001, Pukrop 2003, Obliers, Köhle 2017, Herzberg, Brähler 2017, Schübel 2020, Carstensen 2020), reference is made to the relevant chapter on "Quality of life at the end of life" (§ 22.6) and on "Communication with dying people" (§ 38).

Before the communicative interaction between doctor and patient can be further differentiated in a dialogue-based decision-making model

(§ 7, 10, 22), the current discussion about guiding principles of the "good" doctor must first be pursued, who must ultimately have a number of *key competences* (§ 6) in order to be able to conduct communication with the patient "in accordance with guidelines". To this end, the following chapter also presents our own empirical studies on the question: "When is a doctor a good doctor?", which was posed to professors of medicine as well as GPs.

For the didactics of teaching the key communicative competences in particular, reference should be made to the chapter on the "Learning Goal Communication Competence" (§ 3) and the chapters on clinical communication education and training (§ 13-16).

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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